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A MAGAZINE FOR
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DENTISTS ON THE SPOT

By C. W. GARLEB, D.D.S.

As we know, happily our work is appreciated by a large majority of patients. Some of them are amazed at what good dentistry can do for them—restore wrecked faces; make them look younger; and benefit them in many other ways—morale, character, pride, comfort.

But the picture is not all that bright. Some of the dentistry on which we try so hard to help and to please veers off into troubled waters.

A man's upper denture cracked a year after I made it. It was repaired by one of the best laboratories in the country, but it cracked again four months later. It broke a third time. What was the trouble? The patient's lower natural teeth had been retained because they were still too good to be replaced by artificial ones; therefore, with his lower anteriors retruding, it was impossible to secure satisfactory balance and occlusion. Or was his trouble due to the fact that he chewed so unusually, that is, from side to side? Or what? I had to find the "bug."

After conferring with other dentists and with the laboratory, I made a pressure-cast denture but that broke, too, before the year was out. Finally, a metal screen was incorporated into the plate's palate. At last report, six years later, it was still whole.

The trouble? I believe that this man, a large, powerful individual, chewed some 15 pounds harder than an average person—who would most likely never have cracked the first denture. I did not profit financially, but, more important, I learned a valuable lesson.

No dentist can escape obstacles. Some are real and others are imaginary.

One of my patients came in with a loose root remnant under a fixed lower bridge. "How much to pull it?" he wanted to know. The case looked simple, so I quoted a fee without hesitation. In removing the root I broke a soldered facing off the bridge. The rest was up to me. I had given him an estimate from which, upon my honor, I could not deviate. I removed the bridge, repaired, and reset it—all for the original estimate. It meant many hours of work for nothing. If a patient asked me today "How much?" for a similar service, I would tell him that I would first x-ray the area, and, barring the unforeseen, the fee would range between so much

and so much. This experience gave me a new, sensible slant on fee-quoting for the remainder of my professional life.

And some years ago a colleague told me of one of his cases that put him on the spot. He is a fine craftsman and deeply interested in "doing what's right" for his patients. (Shouldn't we all be like that?) A patient moved in from another town where he had a removable bridge installed a week before with instructions to see a dentist for adjustments if necessary.

But Dr. G told me there was no possible way to correct the ill-fitting appliance, so he made a new one for half his usual fee. "The profession owes this man some money on a new bridge," he insisted. But since that happened, Dr. G has repaired teeth for the man's entire family of seven—for 24 years. They have also sent friends for dental work and these in turn have recommended still others. And so Dr. G's little practice grew big.

Promises, if we dare make them, often put us on the spot, too. So don't promise cures, fits, guarantees, whatnot.

And for this next case a prosthodontist might have had a solution. I didn't. I made a denture for a man whose mandibular bridge was all but missing. I told him it would be difficult, but not impossible, for him to learn to wear the lower denture, and why. I extended the lingual flange down and back as far as I dared but he complained that he could not wear them. (He didn't try.) No amount of extra explaining and coaxing helped. After several months he thought he had located a better dentist than I, who dared to promise him a fit. But there was no fit. Three years later the disgruntled patient was wearing his upper denture but no lower—and likely he never will.

There is an old saying, "Do your best and leave the rest." So we take chances on uncertain cases. What else? If we leave the rest to the patient and he wears his dentures, he profits but if he is not sufficiently interested in making the necessary effort to learn to wear them, even with all our patient help and coaxing, it is no fault of ours.

Every so often you and I see poorly-constructed, ill-fitting dentures being worn successfully, even though they might look hideous and be off balance, while other patients have neither the pride nor the will to learn to wear better ones. Right?

"I'LL NEVER FORGET THE FIRST DAY YOU CAME IN HERE, CHARLIE, ALTHOUGH, GOODNESS KNOWS, I'VE TRIED!"

Then there are teeth from which walls crack soon after we insert fillings or inlays. "What are you going to do about it?" a patient of mine in such a predicament wanted to know. "Will I have to pay again?"

"Well," I replied, "it is not my fault that your tooth broke, but since you had this mishap so soon after the tooth was filled, I shall not charge you to repair it." The patient did not desert me.

Porcelain caps break too. Or they may loosen easily if we prepare them for teeth we have tapered down too much. Now, however, we have plastic caps, which, if placed over less taper, will stick better and are less likely to break. But can we charge a full fee every time one of our new caps breaks or is lost soon after we cement it? No. To keep our patients we had better charge less for such "accident" cases. We may lose money, but we gain valuable experience.

Speaking of accidents, you probably will agree that many of those porcelain facings cracking off happen from abuse and not from normal usage.

Patients have told me, "I never dropped it." True, most of the time. But surely some of the millions of dentures we repair each year were dropped or somehow subjected to abusive use. I have heard of babies playing with dentures, pups chewing on them, hot water warping them, and so on. During my practice I have made six dentures for people who flushed theirs down toilets. This comes under the on-the-spot theme, too, if it happens to one of our brand new dentures. Then most of us would probably deduct part of the usual fee for a new denture.

Since our patients are not familiar with the various extraction problems, it is wise to condition their minds before such surgery. For example, I needed a half hour to remove a tooth, broken apex and all, and my patient wanted to know why it took Dr. X "only three seconds to pull one." I was on the spot. So I explained to him what happens to all dentists sometimes.

We must learn the know-how of making allowances and adjustments and keeping our financial losses as low as possible, just as should anyone else who practices a profession or business.

6408 Chippewa Street
St. Louis 9, Mo.

By C. SHIELDS

A practical library indexing and filing system that makes wanted material available within minutes

A dental office library can be as helpful as a third hand and as valuable as a postgraduate course when the papers, reports, and articles it contains are kept so they may be located easily and quickly.

This is no trick at all if the interesting job is planned efficiently and then made a regular part of office procedure. The method outlined here will accomplish these objectives, and it is not necessary to have majored in library work to put it to use in your office.

In many modern library filing systems the alphabetical arrangement of items has been abandoned in favor of procedures that group material according to subject matter instead of individual titles. This is accomplished in the method suggested here through a combination of letters and numerals used to identify each filed piece.

The plan works this way. Say you wish to save an article dealing with the importance of inquiring into the physical health of patients before undertaking certain operations. You simply clip the pages and write or type in the upper right hand corner of the front page the letter A, and follow this with the numeral 100. The letter A classifies the subject, in this case Physical Health. The same letter is then placed on the tab of a conventional file folder into which the article is then placed. Later, as other articles or reports are added on the subject of patients' medical histories, each one is identified with the letter A but followed by the numbers 101, 102, 103, according to their sequence.

As each piece is filed a 3 x 5 card is typed that gives the identifying letter and numeral of the filed article and its title. These cards are grouped in a box file according to their letter, with the individual cards arranged numerically. The same arrangement applies to the folders. They are placed alphabetically in the file cabinet, the material in each one according to number. While the letters B, C, D, and so on identify each new subject classification, the filed material in each starts out with the 100 designation.

A - 100

Dental Case Histories should include Physical Facts

The trick of keeping this type file simple yet practical is linked with the use of as few classifications as is possible. Although in his professional operations a dentist may cover 101 different steps, many of these contribute to one professional objective. This makes it practical to group related material within one folder. Dental extractions, as an example, is a broad subject, yet some men in general practice may find a single folder adequate to their needs. The specialist on the other hand probably will file much more material on this subject and thus may find it much more helpful to subdivide this classification. In many offices combinations may be applied to other topics. Discussions on fees, for instance, may be filed in the same folder with billing and collection technics.

Incidentally, the letter identifications for subjects need not be established in advance. An as-you-go plan will prove entirely satisfactory. As the dentist marks each piece to be filed, it will take but a moment to determine if a new letter designation is necessary or if one in use covers the subject. A folder on equipment advances, for instance, may also hold articles that explain operation and maintenance of present equipment. A section on foods as it applies to general health may also carry information of caries-fighting diets.

It is important to bear in mind that the value of this filing plan lies in its grouping of like material. A dentist who has some question about hand instruments, for example, need not search his file of library

material from A to Z for the answer. Everything on the subject will be carried in one division of his library. By referring to his box file under the proper letter, he simply thumbs through the subject cards, jots down the number of the library material he wishes to review, and then picks these pieces from his library folder. When they have served his purpose the items may be returned without any question as to their proper location.

Up to this point the details given have been concerned solely with articles clipped from professional publications, material furnished by manufacturers, special studies, and the like. However, the same plan may—and should—be extended to apply to the information contained in bound dental books. These, of course, need not be placed in file folders. The technic here is simply to place chapter titles on the 3 x 5 cards, file the cards in the box file, and return the book to its library shelf position. In this way everything in the dentist's library is indexed and classified. Books that confine themselves to a single phase of professional operations may not need to be broken down chapter by chapter but the book itself should have a card in the proper division of the box file.

Once the indexing of library material has reached a point where all general classifications have been established, a Subject Division sheet should be prepared in triplicate. This is a one-time job that lists subject classifications alphabetically. One or more letterhead-size sheets—8½ x 11—may be used for this purpose. A folded copy should be placed in the front of the card file box, one in the general files as a permanent record, and the dentist will want to keep one in his operating room or at home, depending on where he does most of his reading. With a Subject Division sheet by his side, he may immediately mark for proper filing any article or paper he wishes to have included in his permanent library material.

LIBRARY SUBJECT DIVISIONS

A - *Health* (Physical) Dental and physical case histories . . . pre-operative questioning . . . consultations with physicians

B - *Reception Room* Furnishings . . . Lighting . . . Children

C - . . . . . .

In those cases where a piece of material to be filed touches on two subjects of interest, the classifying simply calls for typing out two cards so the article may be cross-indexed. As an example, an article may discuss the handling of children while they are in the operating room chair and then offer a suggestion for a reception room addition that may help condition a reluctant child patient. If the dentist's subject breakdown includes a CHILDREN classification and also one for RECEPTION ROOM, a card placed in each file box division under these headings will make the material easy to locate later.

". . . YES, AND I WISH SHE WAS BACK ON THE STAGE."

In most dental office libraries, 15 to 20 letter divisions will satisfactorily classify all the library material. This is not inflexible however. As indicated earlier, some specialists may wish to make that many groupings of the material to which they give most of their professional attention. Since each dentist's needs vary greatly according to the nature of his practice, no specific list of divisions has been suggested in this discussion.

After a dentist has completed his library indexing, it is possible he may find that one classification is too general or another too bulky for convenient handling. In such cases the material may be subdivided without confusing his filing plan. As an example, he may find that classification H which covers the subject of DENTURES is much too broad. He may continue to use H for DENTURES (full) and establish a second section HH DENTURES (partial). The material that goes into the second grouping may be properly classified simply by adding another H and renumbering the individual cards and the items to which they refer, starting with 100, 101, 102, according to the need.

Classifying a dental office library calls for a combination of some work and considerable determination. But both pay valuable dividends. In one office the job was lightened by the assistant who typed only five cards a day as she put the related material into their proper folders. She progressed steadily, and the work never did become an annoyance. The potentials of the library increased week by week, and, equally important, the material it contained could be found quickly.

CHAMPION WEIGHT LIFTER

By HENRY F. UNGER

When Peter T. George, D.D.S., takes off a few minutes from his work at the Schofield Army Barracks in Honolulu, Hawaii, to advise another dentist how to keep physically trim, he speaks with authority.

One of the great weight-lifter competitors in the world, Dr. George, now a captain in the U.S. Army, has entered more official world championships than any other lifter — a total of ten. He has traveled around the world with a United States weight-lifting team. His skills were demanded in competition and exhibitions in South America, Australia, and nine times in Europe.

The Champ in Munich.

The dentist who began his amazing career in a makeshift gymnasium in a small Akron, Ohio, garage in order to develop his skinny body, is today no longer training for competition, but rather, after dental hours, trains future weight-lifting prospects. In perfect condition, he continues to exercise with the bar bells three times a week, convinced that this type of exercise is particularly beneficial to dentists whose work makes them remain stationary. He is convinced that bar bell workouts tend to stimulate a dentist's circulation. He advises the busy practitioner to spend about 15 or 20 minutes, three times a week, to keep in reasonably good physical condition. He particularly warns the exerciser who trains at home to follow the instructions on a new bar bell set carefully. Dr. George spends about one-half hour at each exercise session and, even though the weights he uses are heavy, his good condition permits this.

Just recently, because of the admission of Hawaii as the 50th State in the Union, Dr. George received the honor of becoming the first of a group of dentists who were officially licensed in the State of Hawaii. He is also licensed in Ohio and he has his national boards.

The Army dentist's weight-lifting career began when he was just 14 years of age and when he won the Ohio State featherweight (132 pound) class championship. At 15 years he pushed ahead to the lightweight (148 lb.) class and became the national junior champion. At 16 he grabbed the national senior champion rating. He was North American champion at 17 and copped the world title at 18 in Philadelphia. When the London Olympics were announced, young George decided to move into the 165-pound middleweight ranking. He was just 19 when he broke two Olympic records and placed second to another American. His records were 270 snatch and 341 clean and jerk.

Bewildering older competitors, George the following years competed in Holland and Paris, picking off second positions to Kadar el Touni of Egypt. He again beat Touni in Milan, in 1951 and brought home the world middleweight title. Really rolling along, he won a first and set three Olympic records (281 snatch, 347 clean and jerk, and 892 total) in the 1952 Helsinki Olympics.

American weight lifters found themselves in a

quandary the following year in Stockholm when they discovered an abundance of middleweights on their team but no good lightweight who could tangle with the Russians. George, determined that his team should win, decided to reduce, and against the Russian champion, Demitri Ivanoff, he had to break the existing world lightweight record of 809 with a mark of 815 and won in a very close contest.

First places were rolled up by George in the 1954 world championships in Vienna and in 1955 in Munich.

During an exhibition performance in Honolulu after the 1956 Melbourne Olympics, George was trying to hoist 380 pounds to his shoulders and the platform on which he was standing crashed. He tore ligaments in a knee.

Determined that he must give more attention to his dental career, George closed out his weight-lifting career in 1957 in the world championships held in Teheran, Iran. A serious case of dysentery a few days prior to the contest, however, prevented George from competing.

Retired from weight lifting at 28, George recognized that most lifters reach their peaks somewhere between 30 and 35. After 14 years of intense competition, the amazing George could claim his share of top victories.

Dr. George took his predental work at Kent State University from 1948 to 1952 and his dental school work at Ohio State University from 1952 to 1956, where he obtained his D.D.S. He has just completed his last few credits for his B.S. degree. Dr. George accepted a commission from the U.S. Army immediately after completing dental school. His only permanent assignment has been at the Schofield Barracks in Hawaii. He particularly enjoys working with children and he hopes to specialize in pedodontics or orthodontics when he is released from the Army in June.

His wife, Catherine, is a dental hygienist and a graduate of Ohio State University.

Dr. George's weight-lifting feats have overshadowed some of his other accomplishments. He is vice-president of the Hawaiian chapter of the U.S. Olympians. He enjoys singing, has been a guest vocalist for the "Concerts by the Sea" at the Moana Hotel in Waikiki, and often sings at supper clubs. While he was in Stockholm, he had a one-week singing engagement at the International Variety Theater. In Sweden he also recorded "Ole Man River" for RCA.

He is concerned about our weight-lifting race with Russia in the international competition. He says that country is training millions of weight lifters. In Honolulu he is busy contributing his champion's knowledge to the development of future American champions.

At Schofield Barracks Dental Clinic.

Coaching youngsters, Schofield Barracks.

Doing his stuff at Melbourne.

THE MASTER FORCEPS

By MARC TYLER

Think what you will about the story I am about to tell, I believe it. At least, I want to believe it. But I cannot prove it; I have only the Old Man's word that it contains "more truth than you think."

The Old Man, as I remember him affectionately, was Dr. Josef Haller, professor of oral surgery at the University of Vienna Medical College. A little man, with thin, bony hands, a full head of pepper-colored gray hair, the thin, metallic-framed glasses, and the ever-present gleam of eternal wisdom in his youthful eyes.

Some months ago when I was in Vienna with my wife, I dropped in at the university to learn what I could of their dental program and met him.

His office was not unlike that of any American oral surgeon—clean, orderly, and with the most modern equipment. I questioned him regarding the type of surgical instruments he favored.

He smiled, "You are like most students at a lecture," he said. "The first question they ask the clinician is about the type of instruments he uses. You can be sure, doctor, that Pythagoras solved many a complex mathematical problem without a mechanical pencil."

I was embarrassed at my sophomoric approach, and he noticed it. "But, since you asked about instruments," he said thoughtfully, "have you ever heard of the Lorenz forceps?" I said that I hadn't. "Good," he answered, "then permit me to tell you the story."

The Lorenz forceps was designed in 1919 by the master silversmith, Johann Lorenz, for Dr. Hans Budwik, the son of a life-long friend of his, who had just been appointed head of the oral surgery department of the Vienna Medical College, the youngest man so honored. The forceps was of a secret metal alloy; its unique design, specific measurements and balanced weight made it an instrument of sheer perfection and beauty. It was truly the only forceps of its kind in the world. Besides, it was what you might call a "universal" forceps in its function. It could be used for the removal of any tooth in either the upper or lower arch. This magnificent instrument soon gained for Hans Budwik the reputation as the greatest exodontist in all Europe. No tooth was too difficult for him to remove and no operation took more than a few moments. People came from far and wide to have their teeth extracted by him. Even members of royalty visited the clinic, some of them coming from the far-flung kingdom of Siam. For ten years, with the use of the master forceps, the Viennese dentist successfully removed thousands of teeth. His surgical instrument became his most cherished possession. Each day, when the clinic was closed, he placed the forceps in a velvet-lined box and carried it home with him.

One rainy day he hurried to enter his home and left the case with the forceps behind in the hired carriage. When he discovered that the instrument was gone, he offered a huge sum of money for its return, but no one came forth to claim the reward. From that moment on, the famed surgeon refused to operate. He was a lost and dejected man. His health suffered. Finally, his wife sought out another craftsman, for Lorenz had long since passed away. With her knowledge of the instrument's design and specifications, she pleaded with him to duplicate the missing forceps in stainless steel. The craftsman did. Mrs. Budwik presented it to her husband, telling him that some beggar had found it. Believing it to be the original Lorenz forceps, the surgeon was elated. In a short time he again occupied the throne of exodontics.

When the craftsman learned of the power of the instrument, he made many more of them. Eager dentists who wished to acquire Budwik's skill and fame bought the instruments as fast as they were made.

"And did the instruments help them?" I asked.

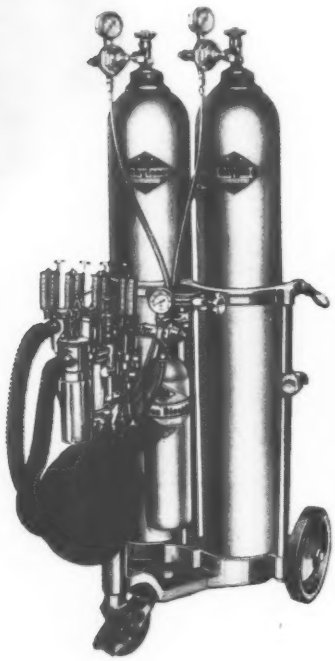
"Only a few. As for the others, the surgery clinic was flooded with patients complaining of broken roots, lacerated tissues, and painful infections." He grinned slyly. "Actually, there is more truth in this story than you might imagine. For, in reality, is not the measure of one's skill in his hand and not in his instrument?"

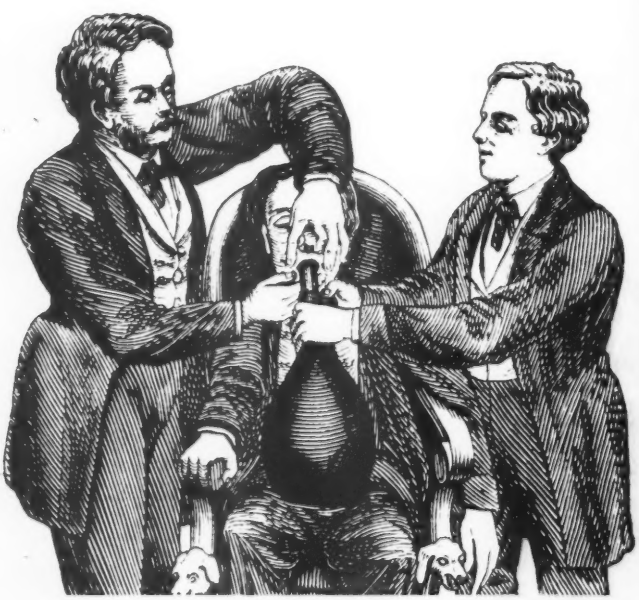
Anesthesia
THE STORY OF DENTISTRY

ANODYNE OF THE AGES

EARLY ANESTHESIA INHALER

DR. HORACE WELLS





"SLEEP IS WELCOME THAT INDUCES PAIN TO PART"

ARABIAN NIGHTS

CONQUEST OF PAIN

BOOK ONE: CHAPTER II

Much of the history of man is a record of his everlasting struggle to conquer pain—pain in body, in mind, and in spirit.

Primitive man, his mind in the darkness of the womb of unborn intellect, lived in a fearful world dominated by gods who tormented him with a thousand-and-one bodily pains.

He tried to appease those gods by the practice of magic, the wearing of amulets, the paying of homage to animals, and the worshiping of the sun and other elements of nature.

Relief from toothache was sought in showing reverence for animals with strong teeth. Transference was practiced. A piece of bark was forced into the gums until they bled, and then the bark was replaced in the exact spot on the tree from which it had been stripped.

But God gave man imagination and that sight inside the mind eventually led man out of his ages-long nightmare. One day, perhaps one of the greatest days in all human history, man achieved the impossible. . . .

It all happened little more than a hundred years ago—on the night of December 9, 1844. Horace Wells, a dentist of Hartford, Conn., dropped in on a "lecture" on chemical phenomena that was being staged by Gardner Quincy Colton. Colton was a chemist and a showman. He traveled about the country demonstrating, in theatrical fashion, various developments in chemistry.

That night he was dramatizing the properties of nitrous oxide, or "laughing gas." He asked members of the audience to come to the stage and inhale fumes through a tube, the other end of which was inserted into a bag containing the gas. Some volunteers who inhaled the fumes reeled and staggered back to their benches. They struck and bruised their legs against the benches. Normally they might have cried out in anguish; but, under the influence of nitrous oxide, they showed no evidence of experiencing pain.

Horace Wells was a man with a restless, searching, wondering mind. He looked at these bruised volunteers and suddenly got excited—very excited. One of the greatest ideas of all times occurred to him. Immediately after the "show," he hurried to Colton and got the chemist to agree to come to his dental office the next afternoon with a bag of nitrous oxide.

That next day, Wells, still trembling with excitement, greeted Colton and introduced him to another man in the office, John M. Riggs, a dentist. Wells had Colton administer the nitrous oxide to him. When Wells became unconscious, Riggs extracted an aching molar from Wells, who thus became the first patient in history to have a dental operation performed on him while under general anesthesia. It was a painless operation. It was probably the most important operation ever performed, for it introduced the era of anesthesia.

Two years later another dentist, William Thomas Green Morton of Boston, a friend and one-time professional partner of Wells, employed ether anesthesia to extract a tooth without pain. A few days later, on October 16, 1846, he demonstrated the efficacy of ether as a general anesthesia before a distinguished audience of physicians and surgeons in the surgical amphitheatre of the Massachusetts General Hospital in Boston. So impressive was Morton that his demonstration has always been regarded as the most famous incident in the history of anesthesia.

The discovery of chloroform came shortly thereafter. Then the use of cocaine, in 1889, to block the nerve in the lower jaw, opened the way for local anesthesia. Dentistry needed a local anesthetic more than general anesthesia, for dentists required a drug that would kill sensation in the tooth, gum, or nerve, without rendering the whole body unconscious. Procaine was such an anesthetic. Introduced in the early part of this century, it did for dentistry what ether and chloroform had done for general surgery.

Today anesthetizing the windpipe makes it possible to do restorative dentistry on cerebral palsy victims and the mentally retarded.

Routine cavity preparation and rehabilitation of carious teeth by fillings can be done in one operation—in some cases. This means that some patients can walk into a dental office with an ailment and leave that office a short time later completely cured of that condition.

In cases where extended operations that might previously have required several dental appointments but can now be done at one time, an important benefit is made available for highly nervous, apprehensive patients.

Dentistry as a profession has done much to make the world a better place to live in. But none of its achievements are greater than its discovery of surgical anesthesia, for that discovery made it possible to reach almost any part of the human structure for surgical exploration and intervention—without pain to the patient. Thus dentistry opened the doors to all the miracles of modern life-saving surgery.

Dentistry gave surgery its greatest tool, anesthesia, and mankind one of its greatest blessings—freedom from pain.

CONSTRUCTING A TEMPORARY BRIDGE

By MAURICE J. TEITELBAUM, D.D.S.

Before the advent of the quick-curing acrylic resins, one of the most annoying and time-consuming tasks facing the dentist was the fabrication of an anterior temporary bridge wherein multiple abutments were present. Generally, the prepared teeth were covered with celluloid crown forms, preferably faced with silicate filling material and filled with a zinc oxide cement. The use of these temporary coverings, while satisfactory for a single tooth, required too much chair time when used on multiple abutments. Because two or three visits were necessary for the fitting of castings, and the soldered bridge, these temporary crowns had to be removed each time and, because of their fragility, had to be discarded and new ones constructed. At times, patients required an extra appointment because the celluloid was torn, fell off or became frightfully discolored. All in all, the time it took to cut, fit, place, remove, and remake these temporary crowns often required as much chair time as the actual preparations of the teeth. Anterior teeth to be extracted or missing were often replaced temporarily with a simple one or two tooth palatal partial which was a great persuader against dining out.

The quick-curing acrylics changed all of this. Without going into the pros and cons of acrylic as a suitable material for permanent jackets or for veneer crowns, in the construction of a temporary bridge or temporary jackets it is most satisfactory. This acrylic material is easy to handle, sets rapidly, meets esthetic requirements, and is durable. Its strength enables it to maintain its form so that it may be used again and again when removed for the fitting of castings, and so forth. Furthermore, any holes or cracks in the acrylic that may develop can easily be repaired. Following, is a step-by-step procedure in the construction of a temporary anterior bridge using one of the self-curing acrylic resins.

In this actual case, the patient was an attractive woman in her early thirties. The cuspids were well formed, although both of them had old discolored silicate fillings in the mesial surfaces. The laterals were what we describe as "hourglass teeth"—gross carious destruction of the mesial and distal surfaces. These teeth were exposed and were to be extracted. The left central had a fractured distal corner and the right central had a labial silicate. The proposed treatment was the removal of the laterals and their replacement by a six-unit cuspid to cuspid bridge, using four veneer crowns and two lateral pontics.

STEP 1. PREPARING THE MODEL.

The construction of the temporary bridge began during the patient's initial visit when impressions were taken for study casts. A duplicate stone model was made of the upper cast and that became our working model. Using red wax or carding wax, the broken laterals were restored on the model to proper contour and the fractured corner of the left central

"WELL, IF YOU CAN'T PAY IT THIS MONTH, I'M AFRAID I'LL HAVE TO TAKE DRASTIC MEASURES . . . AND REST ASSURED, THIS IS NO IDLE THREAT. OF COURSE, YOU REALIZE THERE'S NOTHING PERSONAL IN THIS, MOTHER."

was restored. The more time taken in waxing the model teeth the less chair time needed in trimming down or adding to the temporary acrylic bridge.

STEP 2. PREPARING THE SHELL

The entire skeletal part of the temporary bridge was then constructed without the loss of any chair time. It was prepared before the patient arrived for the preparation of the teeth and the extractions. An alginate impression was taken of the six anterior teeth in the waxed-up study cast after they were treated with a thin coat of vaseline. A regular sectional bridge tray was used instead of a perforated tray to facilitate the lifting out of the impression material when the shell was finished. The alginate material should be a dark or pink color, rather than white or yellow so that the acrylic material placed in it will be easily discernible. The impression was thoroughly dried and ready for the painting in of the acrylic shell. Using a fine paint brush, the shell was prepared by alternately "painting" in the acrylic liquid and then the acrylic powder. The labial surfaces were painted in first by holding the impression so that the labial surfaces were parallel to the floor. This prevents the running of the material over to the occlusal surfaces. The thin layer of acrylic hardens rapidly. After carefully drying it with a blast of air, the impression was turned over and the lingual surfaces of the six teeth in the alginate were painted with the acrylic liquid and powder. Finally the occlusal was done and the impression was set aside to harden. Within 15 minutes to a half hour, the shell of the acrylic temporary bridge was hard enough to be withdrawn from the alginate. This was done by removing the impression from the tray and then bending the alginate and lifting out the skeletal portion of the bridge. This acrylic shell was then placed in water until ready for completion.

STEP 3. COMPLETING THE BRIDGE

When the patient arrived for her appointment, she was anesthetized and the abutment teeth prepared and the laterals extracted. When the sockets were clotted, the final steps in the construction of the bridge began. The shell bridge was held over the anterior teeth to check the approximate fit and the thin pieces of excess acrylic around the gingival margins were trimmed with a pair of shears. Then a putty-like mix of acrylic was made and placed into the shell. The laterals, which were to serve as pontics, were filled completely. A thin coat of vaseline was placed over the prepared centrals and cuspids and the bridge was gently put into place. When the initial set was started, the bridge was teased off and the soft acrylic excess was trimmed away. The bridge was then put back on the teeth and carefully worked

"TAKE ONE BEFORE YOU GO TO BED AND ANOTHER IF YOU WAKE UP IN THE MORNING."

on and off until the acrylic was set. This procedure eliminates the danger of heat on the prepared teeth during the final setting of the acrylic and prevents the bridge from being locked into place too securely.

STEP 4. POLISHING AND CEMENTING THE BRIDGE

The additional excess around the hardened bridge was trimmed with disks and the bridge was polished with pumice and tin oxide. New brushes are used so that the acrylic does not become discolored. Kadon polishing powder may also be used to give the acrylic bridge a high gloss. The bite was adjusted (very little or no adjustment is usually the rule) and the bridge was cemented into place with temporary cement to which a small amount of vaseline was added to facilitate removal.

Thus the patient was able to leave the office with a comfortable, good-looking, and serviceable temporary dental restoration without the loss of more than 20 to 30 minutes of chair time. At the next appointment, when impressions were taken, the bridge was easily taped off, cleaned out, and recemented when the patient was ready to leave. This was repeated during the fittings of the castings and the soldered bridge.

This technic, and variations of it, can be used for the construction of all types of temporary bridges from three to 14 units. Missing teeth can be incorporated in the bridge by waxing up teeth on the working model so that the alginate impression to be painted in has the tooth in it as a pontic.

446 Clinton Place
Newark 12, N. J.

The Southern California Dental Hospital in Los Angeles.

TOMORROW'S HOSPITAL TODAY

By KAY LIPKE

The world's first hospital completely designed, built, and equipped for dentistry is in operation in Los Angeles, Calif.

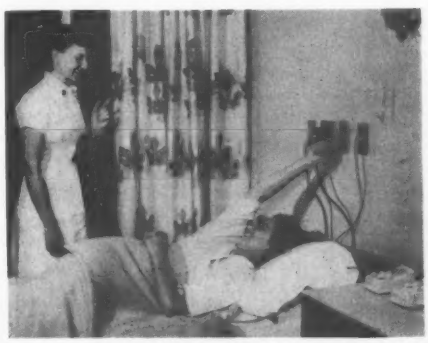
The Southern California Dental Hospital is "the last word in decoration, design, and in ultra-modern dental and hospital equipment." It has been created to meet the dental needs of tomorrow as well as today. The American Hospital Building Corporation has financed, built and equipped this $1,750,000 structure. It is managed by the American Hospital Management Corporation, which manages other hospitals throughout the West.

The Los Angeles County Dental Society was instrumental in the original planning, and the dentists who form the staff are members of the Society. At present there are between four and five hundred dentists on the staff. As the hospital is now fully operative, the Society acts in a liaison capacity. Dr. Leonard McEvoy, president-elect of the Society, is the hospital's chief of staff. Mac Buhler is the administrator.

Oral surgery, general practice, periodontics, and pedodontics are practiced in the hospital which has been designed to help satisfy the growing demand for operative dentistry under a general anesthetic.

In a sense, the Southern California Dental Hospital is an experiment, as all entirely new projects are.

Los Angeles was chosen for this first dental hospital because of its enormous, steadily growing, population, which has resulted in a serious overcrowding of its hospitals. For some time there has seemed to be a need for a hospital designed for dentistry, where oral surgeons could take their hospital cases and general practitioners could place patients facing a large amount of operative work which could be done



A private patient room. "Patient" is operating switch for electrically controlled drapes.

more quickly and easily under a general anesthetic.

At this hospital, the operative dentist can perform the most intricate dental work, while the patient is completely relaxed under a general anesthetic. Everything is furnished the dentist, including all instruments. A skilled M.D. anesthesiologist is in charge. Since the work can be done in one treatment, it is time and money saved for both the dentist and the patient, according to those in charge of the hospital.

The patient relaxes in harmonious surroundings in either a private or semi-private room, with radio, TV, and adjoining enclosed patios. For the day patients, there are attractive recovery rooms, equipped with oxygen.

Facilities in the hospital include 16 operating rooms, 4 equipped for oral surgery, and 12 for operative dentistry. Each includes the latest in modern high-speed turbine drills and high-velocity vacuum systems; also complete cardiac arrest equipment, including a heart pacer, defibrillator, cardio-scope, and EKG recording machine, as well as equipment for administering a general anesthetic under a qualified anesthesiologist.

A two-way communication system connects with patient, operating, and recovery rooms. A closed-circuit television system, with one operative and one oral surgery operating room connected with the dentists' lounge and dining hall (which can be converted into a meeting hall), permits dentists to observe the use of new technics in an actual operation.

There are 30 recovery rooms and 50 patient rooms. In addition to bedside controlled television, these rooms have electrically controlled drapes and beds, and enclosed patios with sliding glass doors.

The latest in laboratory and x-ray facilities are provided. The kitchen is equipped and staffed to prepare special diets requested by dentists for their patients. Complete general anesthetic facilities are available at all times for all types of dentistry. General anesthetics are administered under the supervision of William N. Scott, M.D., or a member of his staff.

Prior to the administering of a general anesthetic, each patient is given the regular medical check-up required for health safety. Preoperative tests are quickly processed in the hospital's complete medical laboratory. However, the hospital does not maintain a dental laboratory in competition with fine existing local facilities.

It is possible for the patient to take advantage of all outpatient and inpatient facilities at a set fee. This fact has aroused interest among insurance companies and several companies have expressed the belief that the entire all-inclusive day rate can be included in their policies without any increase in their current insurance rates.

Privileges of staff dentists of the Southern California Dental Hospital are similar to those of physicians in a general hospital. To make use of hospital facilities, the staff dentists merely call the hospital for a scheduled appointment.

Immediately, the hospital's IBM scheduling and recording system sets up the appointment, records the necessary information, prepares confirmation notices for both the dentist and his patient, and sets up a permanent medical record and billing invoices. There is a special intercom system, connecting all areas of the hospital, which enables the dentist to pick up a phone and record special data—or even to request permanent recording of the cardiograph.

In addition to Dr. McEvoy, the chief of staff, others associated with the hospital include Dr. Robert Read, pedodontics; Dr. Howard Tyrell, periodontics; Dr. Ernest Rowe, general practice; and Dr. R. L. Fowkes, chairman of the credentials committee.

Time reported in December that the hospital had few patients during the last quarter of 1959. But that story, plus publicity on the Dave Garraway TV show, brought the hospital almost 1,500 inquiries from people wanting to know about its services. According to reports, the number of patients is increasing, and the management is optimistic that the dental-hospital idea will catch on.

1993 Lucile Avenue
Los Angeles 39, Calif.

Scene depicts simulated postoperative treatment for "patient" Rosemary Thorpe. The nurse is Zoela Zavas.

Dr. Leonard McEvoy, hospital chief of staff, in one of the four oral surgery operating rooms.

William Scott, M.D., chief anesthesiologist, is demonstrating equipment in an operating room.

A Memoir Of World War II

By JAMES O. GOLDMAN, D.D.S.

When I look into the mouth of a patient I am examining, I get many clues to his character, habits, and physical condition. But this week, when I examined a soldier who had four anterior teeth missing, I had no clue to how he could have lost them. When I routinely inquired, I hardly expected the story that followed.

It started back in 1941 when Pvt. Nikola M. Topalovich, now a soldier in the United States Army, was a seaman in the Royal Navy of Yugoslavia. He had been in the navy for 18 months, before that he had helped his father farm. Nikola was on a training mission aboard one of the three vessels that comprised the Yugoslavian navy. They were in the Adriatic Sea.

Nikola's ship was captured by the Germans, and its entire crew taken as prisoners. The downfall of his country was complete and fast from that time on. Within 15 days Hitler's legions had overrun the entire country. The 16 Nazi divisions were too much for the small nation. The navy capitulated—all three surface vessels and all three submarines.

Soon after, Nikola was captured by the Germans. He was placed aboard a train with typical prisoner-of-war "accommodations"—he occupied a box car with 200 other Yugoslavians.

Thus he left his native country, his twin brother and his older brother (both members of the Yugoslav army) his mother and father with whom he had spent all his years on their little farm—everything that he had ever known. His destination—Stalag 3B, Vienna.

Life in Stalag 3B was not too bad for Nikola because his duties were agrarian, and the German farmers fed him well. He spent one and a half years there and was sent to Salzburg for the same type of duty for one year.

At the end of this year his well-fed, agricultural bliss ended. He was sent to Nuremberg and assigned to a gang of laborers whose duty it was to clear the streets of the rubble created by mass air attacks of the Allies. The work was hard, and the food was poor.

Despite the arrival of Red Cross packages from Geneva, Nikola started losing weight because of the inadequate diet and the extremely long working hours. When packages arrived, they had been opened by the German guards who had relieved them of everything that they wanted. What was left was turned over to the prisoners, who pooled their contents in an effort to secure a few decent meals.

No packages ever arrived bearing cigarettes, for they were the first things that the guards removed. They did, however, issue one and two cigarettes a month to each prisoner.

Early one morning Nikola's name was called, along with the names of 16 other prisoners. Why? He didn't know. He just happened to be one of 17 selected to be sent to the most famous of all the infamous German concentration camps—Dachau.

When I listened to Nikola's description of the experiences he endured at Dachau, I was sorry that I had asked him how he lost his teeth, because his account seemed to bring all the horror of his stay there fresh to his mind.

Nikola had had his four anterior teeth capped with gold while he was a youth in Yugoslavia. When he arrived at the Dachau camp, these were extracted—not because there was anything wrong with the teeth but because this was the practice of the Germans in their effort to secure gold. The extractions were done, not by a dentist but by a guard, and without the use of an anesthetic.

Another procedure practiced on Nikola, as well as all the other prisoners, both men and women, was the shaving off of all the hair from their bodies.

No food of any nourishing value was given the prisoners. They were given three potatoes daily—"one that was green, one that was rotten, and one that was no good"—and coffee that was brewed from barley that had been fried then ground.

On one occasion a Russian prisoner died, and his fellow prisoners found his meal tickets in his pockets. So that they might secure a few extra rations, several prisoners hid his body and covered it with canvas.

It was a month before the body was discovered.

For the few prisoners that were still able to work, work was the order. The others were tortured. One of the favorite tortures practiced by the guards was to make the prisoners run around a rock-covered road in wooden shoes. Few were able to do more than a slow-paced shuffle. The ones that fell or got out of line were beaten with a short whip, the blows of which were capable of breaking a man's neck.

During Nikola's entire stay at Dachau, he didn't care whether he lived or died. Escape was impossible because the prison was surrounded by an electrically charged barbed-wire fence. He lost weight until he weighed 90 pounds, compared with the 150 he had weighed when he arrived.

The prisoners ate anything that they could swallow to relieve the pains of hunger that continually beset them. Nikola ate all the newspapers he could find.

One day he received a fatal notice. On the following morning he would be burned in the electric ovens. During the night, as he lay on an over-crowded floor, he prayed. It wasn't the first time that he had prayed, because his family was religious, and prayer was no strange thing in their home. But this time he prayed more fervently than he ever had, and he prayed all night long.

As dawn broke the following morning, his prayers were answered. United States troops arrived. Nikola could hardly believe it.

As he sat in my chair telling me this story, he turned to me and said, "Doc, don't ever let anybody tell you that there isn't a God, because I know that there is."

When the United States Army started uncovering evidences of atrocities at Dachau, they found 100 cases filled with gold teeth—the teeth that had been ruthlessly pulled from the mouths of the prisoners. In the demoniac storerooms of the camp there were also over 1000 sacks of human hair.

Nikola's rescuers carried him to a hospital in Wiesbaden, and army dentists there made him a partial denture to replace the four teeth he had missing. From the hospital at Wiesbaden, he was transferred to a hospital at Nuremberg where he recuperated for four months. One day while he was at Nuremberg, a young captain in the Yugoslavian army came into Nikola's room and asked him if he would like to go to America to live.

Nikola answered him with a laugh. He thought it was a ruse to get him back to Yugoslavia. But he signed the necessary papers, along with 48 other displaced persons, and decided that, if it were a ruse, he'd commit suicide. It wasn't until he was aboard a vessel bound for New York that he relaxed and decided that he really was going to the United States.

When he arrived in New York he was given $5 for spending money and placed aboard a train for Libertyville, Illinois, where he was received at a Serbian monastery. The bishop in charge of the monastery

Technician at the U.S. Naval Dental School, Bethesda, Md., demonstrates a new optical fiber probe, linked to a closed-circuit television system, called "Insight." The device, which looks like a dentist's drill, is connected to a TV camera which projects a magnified picture of any part of the mouth to a screen behind the patient's head. This permits simultaneous inspection by other dentists or by students.

(U.S. Navy Photo—Wide World)

was a native of Yugoslavia and had lived only 10 kilometers from Nikola's home.

Shortly after he arrived at Libertyville, Nikola celebrated his first American holiday, the Fourth of July. To him it was a two-fold celebration—of his own independence as well as that of the United States. Visitors to the monastery that day gave him $50, a token of friendship that he will never forget.

After Nikola had been in the monastery a short while, Mr. Jack Stein of Cincinnati offered to hire two of the displaced persons to work in his restaurant. Nikola was one of the two chosen and went to work. Not long after, he volunteered for the United States Army—a dream that he had harbored since his release from Dachau. He was rejected, though, because of his scant knowledge of the English language.

Everything went well except his efforts to contact his family. The Red Cross made numerous efforts—all unsuccessful. He assumed that all of them were victims of the Germans except his mother's brother. He had no doubt about his fate, for he was Mihajlovich, the guerrilla leader.

Upon the ascension of Communist leader Tito, Mihajlovich was tried by a so-called people's court and sentenced to death. Nikola had read of his fate in the American newspapers.

In 1951 Nikola reapplied for entrance into the United States Army and was accepted. He was sent to Indiantown Gap, Pa., for nine months' training, after which he was alerted for duty in the Far East. After a 17-day furlough, which he spent working for Jack Stein in Cincinnati, he was shipped to Japan.

He told me: "I am on my way to Korea to fight for the best country in the world, the United States."

He continued, "Doc, you don't know how to appreciate the United States. After you get back home, you will have a deeper understanding of it; but even then, you can't begin to know it as deeply as I do."

When he left my dental chair, I appreciated many things more deeply than I had before.

Marks, Miss.

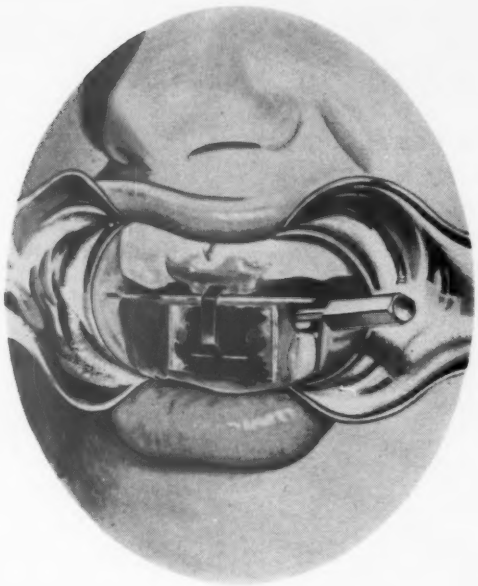
A UNIQUE "BOOK"

The publication and release of a new type of "book" on oral surgery has brought to the dental profession a new opportunity for the use of visual aids in dentistry. *Surgery of The Oral Cavity and The Technique of Controlled Tooth Division,* by Wilton W. Cogswell, D.D.S., is published as 1,400 pairs of stereoscopic pictures of surgical procedures in the oral cavity. These views are mounted in reels of 7 pairs each and are studied through an electrically illuminated View Master focusing stereoscope which is held in the hand. With each slide is a description published in book form, keyed to the three dimensional pictures which the reader is viewing. The book is the result of 11 years of work by Dr. Cogswell, oral surgeon of Colorado and a visiting professor at his alma mater, the University of Kansas City School of Dentistry.

Dr. Cogswell developed the controlled tooth division method for removal of unerupted and impacted teeth and emphasizes this method in his new book. Since good photographs are difficult to obtain while surgery is being performed within the mouth, Dr. Cogswell reconstructed, in wax, many operations from his own practice. The reproductions are so accurate that the inexperienced would have difficulty in recognizing them as wax reproductions and yet so realistic that the experienced dentist or oral surgeon considers them as actual clinical cases.

The operations covered vary from extractions of teeth using the controlled tooth division method to removal of foreign bodies from the sinuses.

HOW'S YOUR BITE ?



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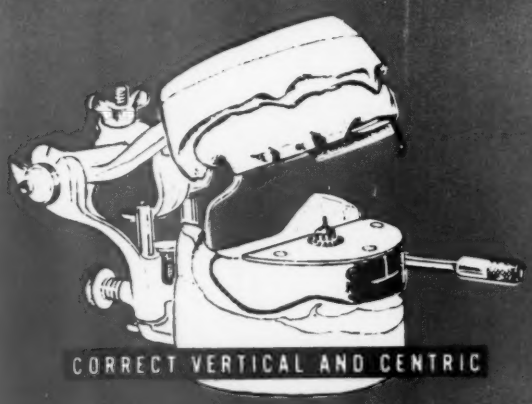

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